Michigan Senate Health Policy Committee

"ALIGNING INCENTIVES FOR HIGH-VALUE HEALTH CARE"

Testimony by:

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Good afternoon and thank you, Chairman Marleau, Ranking Member Warren, Members of the Committee, and invited guests. I am Mark Fendrick, a Professor of Internal Medicine and Health Management and Policy at the University of Michigan, and a member of the University's new Institute for Healthcare Policy and Innovation. I am addressing you today not as a representative of the University, but as a primary care physician, a medical educator, and a public health professional.

Mr. Chairman, I applaud you and your colleagues for holding this timely hearing on the important issue of adding value to our health care system. I completely agree with your assessment that price transparency and more engaged consumers are necessary elements to move us from a volume-based to a value-based system. This transformation involves not only how we pay for care, and but importantly, how we involve consumers to seek care.

I could not agree more with the recommendations of my esteemed colleague, Dr. Kullgren, that the legislature should:

1. Pass Senate Bill 627 to require providers to report price information;
2. Pass Senate Bill 333 to create an all-payer claims database for Michigan; and,
3. Ensure creation of a consumer-friendly website for health care price information.

The crux of my remarks is to make clear that transparency is not enough to achieve our goals of improved health and lower costs. Even when cost and quality data are accurately determined, and readily available, consumers still need better information regarding whether recommended treatments and procedures are clinically necessary. As we are well aware, just because you can get a good price for something, doesn't mean you should always buy it. There is a robust body of evidence documenting the overuse of medical services that produce no health benefit and according to the literature, account for at least 20% of our total health care expenditures. At the same time, life-saving services such as immunizations, cancer screenings, and chronic disease treatments are systematically underused. These are services that I beg my patients to do, such as critical treatments for asthma, diabetes and depression. As a result, several private and public initiatives are underway here in Michigan and across the country, to help consumers understand the pros and cons of receiving certain medical services.

I have spent over two decades studying consumer engagement in health care. **Ideally, consumer cost-sharing levels would be set to encourage the clinically appropriate use of health care services. That means copayments would be used to encourage consumers to think twice or thrice about the services they don't need, but not create financial barriers to services that may be life-saving.** However, with a few notable exceptions, Michigan health plans implement consumer cost-sharing in a "one size fits all" way, in that beneficiaries are charged the same amount for every doctor visit, diagnostic test, and prescription drug.

While I strongly support the notion of personal accountability, asking Michiganders to pay the same amount out of pocket for clinical services that vary tremendously in the amount health that they produce makes seems illogical.

Does it make sense that my patients pay the same copayment for a life-saving cancer drug as one that makes toenail fungus go away? Due to a lack of clinically nuanced incentives, my patients use too little high-value care and too much low-value care.

One possible solution to this blunt "one size fits all" approach is based on the concept of "clinical nuance" or the fact that medical services differ in the amount of health that they produce.

More than a decade ago, the private sector began to implement a concept our team developed here in Michigan known as Value-Based Insurance Design, or V-BID. **The basic V-BID premise calls for reducing financial barriers to evidence-based care, and imposing disincentives to discourage use of low value care. It's common sense - when barriers to high-value treatments are reduced and access to low-value treatments is discouraged - we improve health and save money.**

Let me be clear, Mr. Chairman, I am not asserting that price transparency or using V-BID programs is the answer to our health care problems. But, if we are serious about "bending the health care cost curve" and improving health outcomes, we must change the incentives for consumers as well as those for providers.

In addition to transparency, your committee is currently examining many exciting initiatives, such as patient-centered medical homes and health information technology. If these initiatives provide incentives to clinicians to recommend the right care, it is of equal importance that incentives for patients are aligned with these goals as well. Knowing your experience as a businessman, Mr. Chairman, I think you might find it incomprehensible to realize that my patients' insurance coverage does not offer easy access to those exact services for which I am benchmarked and awarded financial incentives for providing. Does it make sense that I am offered a bonus to get my diabetic patients' eyes examined, when many them have insurance plans that make it prohibitively expensive for them to visit the ophthalmologist?

I'm pleased to tell you that the intuitiveness of the V-BID concept is driving momentum at a rapid pace in the private sector, and is one of few health care reform ideas with strong bipartisan political support. Hundreds of private self-insured employers, public organizations, non-profits, and insurance plans have designed and tested value-based programs.

One of the most closely watched applications of V-BID is its explicit inclusion in the Healthy Michigan Plan legislation, in which **Section 105D(1)(f), requires plans to "design and implement a copay structure that encourages the use of high-value services, while discouraging low-value services." In addition, Section 105D(5), requires plans to "implement a pharmaceutical benefit that utilizes copays at appropriate levels allowable by CMS to encourage the use of high-value, low-cost prescriptions."**

For the State of Michigan to stay at the cutting edge and remain a national leader in health care transformation, I believe that public and private plans should be encouraged to do the following:

1) **Set cost-sharing based on clinical information, such as diagnosis.** Even though the clinical appropriateness for a specific service may vary widely among enrollees, cost sharing for any service is often the same for everyone in the plan.

2) **Vary cost sharing for a particular service according to where a service is provided.** The Commonwealth Fund estimated that nearly $200 billion in savings would accrue to Medicare over 10 years if we were to implement a value-based design that encourages beneficiaries to obtain care from high-performing providers, such as those in patient centered medical homes.

3) **Implement differential cost-sharing based on clinical evidence – not just the price - of clinical services.**

CONCLUSION

As your committee considers changes to transform our system from volume-based to value-based care delivery, it is my hope that you will take the common-sense step to strongly encourage health plans to vary cost-sharing based on the amount of health produced. Given the urgency to bend the cost curve, the legislature should abandon blunt instruments that reduce quality of care, and instead support the use of clinically-driven programs that encourage the use of high value services and deter access to low value ones. **Implementation of a value driven – not cost driven - approach can improve health, enhance personal responsibility, and reduce expenditures.** Thank you.